	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 04/26/2023	
NAME OF PROVIDER OR SUPPLIER: ACCELA REHAB AND CARE CENTER AT SPRINGFIELD			STREET ADDRESS, 850 PAPERM GLENSIDE, P	ILL ROAD	IP CODE:		
STATE LICENS	SE NUMBER: 580502						
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 00000 F 0573 SS=D	Based on an Abbreviat four complaints comple determined that Accela Springfield was not in Requirements of 42 CF Requirements for Long 28 Pa. Code, Common Term Care Licensure Fe health portion of the su	eted April 26, 2023, a Rehab and Care Ce compliance with the FR Part 483, Subpart g Term Care Facilities wealth of Pennsylva Regulations related to arvey process	it was enter at e following at B, es and the unia Long to the	F 0573	TITLE:	(X6) DATE:	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:		
		395545	B. WING: 04/26/2023				
ACCELA I SPRINGFI	VIDER OR SUPPLIER: REHAB AND CARE CENT ELD EE NUMBER: 580502	TER AT	850 PAPERM GLENSIDE, I	IILL ROAD	IIP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DI MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)					OULD BE	(X5) COMPLETE DATE
F 0573 SS=D	Continued from page 1 483.10(g)(2)(i)(ii)(3) Right Records §483.10(g)(2) The resident and medical records pertain (i) The facility must provide personal and medical record upon an oral or written requirequested by the individual, such form and format (inclusted format when such records as if not, in a readable hard copformat as agreed to by the fact 24 hours (excluding weeker (ii) The facility must allow the records or any portions the electronic form or format welectronically) upon request notice to the facility. The fact cost-based fee on the provise the fee includes only the cost (A) Labor for copying the reindividual, whether in paper (B) Supplies for creating the if the individual requests the provided on portable mediation (C)Postage, when the individual mailed.	has the right to access pring to him or herself. The the resident with access as pertaining to him or heest, in the form and form if it is readily producible adding in an electronic form the maintained electronic py form or such other form and holidays); and the resident to obtain a continuous and holidays); and the resident to obtain a continuous and a continu	ersonal s to erself, nat le in m or ally), or, rm and l, within copy of intained vance conable, that	F 0573	R-1's clinical record was proafter R-1's POA completed records request form Current facility Residents remedical records will have the provided timely All current requests will be a and provided to appropriate requestor in appropriate requestor in appropriate reguired timeline by Medical Records/designee A weekly audit will be condappropriate requestor an proper appropriate regulatory retimeline to requestor wkly for weeks and monthly thereafted Medical recrods/designee The findings of the audits we reviewed in Quarterly Councemonthly for three months and quarterly thereafter.	questing em audited alatory l ucted to vided equired or four er by ill be	Completion Date: 05/23/2023 Status: APPROVED Date: 05/12/2023
	3 -21-5 (B)(-) tan and exec	T . J					I

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***************************************		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	I) PROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395545				04/26/2023		
NAME OF PROVIDER OR SUPPLIER: ACCELA REHAB AND CARE CENTER AT SPRINGFIELD			STREET ADDRESS, 850 PAPERMI GLENSIDE, P	ILL ROAD	IIP CODE:			
STATE LICENS (X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE D BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0573 SS=D	Continued from page 2 in paragraphs (g)(2) and (g) must ensure that information a form and manner the residincluding in an alternative for resident can understand. Surinformation described in parmay be made available to the expense in accordance with This REQUIREMENT is not seem to be a surface of the continue of th	n is provided to each resent can access and under ormat or in a language the mmaries that translate ragraph (g)(2) of this see e patient at their request applicable law.	orstand, hat the	F 0573				

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PLAN OF CORRECTION (POC) IDENTIF		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/26/2023	
		395545		B. WING.		04/20/2023	
ACCELA I SPRINGFI	VIDER OR SUPPLIER: REHAB AND CARE CENT ELD E NUMBER: 580502	TER AT	STREET ADDRESS, 850 PAPERM GLENSIDE, F	ILL ROAD	IIP CODE:		
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (FACH	(X5)
PREFIX TAG	MUST BE PRECEEDE	ED BY FULL REGULATORY OF FYING INFORMATION)		PREFIX TAG	CORRECTIVE ACTION SHE	OULD BE	COMPLETE DATE
F 0573	Continued from page 3			F 0573			
SS=D							
	Based on review of clin	· ·					
	facility documentation	•					
	determined that the fac						
	records as requested in	•					
	two closed records revi	iewed (Resident R1)					
	Findings Include:						
	Review of Resident R1	's clinical record rev	ealed the				
	resident was admitted t	to the facility on Jun	e 16,				
	2022. Further review o	•					
	record revealed the res	ident was discharged	d on				
	September 29, 2022.						
	Interview on April 26, 2023, at 10:10 a.m. Medical Records, Employee E3, revealed the facility recently received a medical records for Resident R1 on April 4, 2023.		he				
	Review of documentation revealed a request for a medical records from the representative. The letters	.1's zed					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395545			<u>uu</u>	04/26/2023	
ACCELA I SPRINGFI		ER AT	STREET ADDRESS, 850 PAPERMI GLENSIDE, P	ILL ROAD	MP CODE:	1	
STATE LICENSE NUMBER: 580502 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0573 SS=D	request was dated Apri was the "3rd Request." dated November 1, 202 29, 2022, as the "2nd Records, Employee E3 to recall any requests ff 2022. Medical Records the medical records rec	The letter was orig 22, and again on Dec 22, and again on Dec 22, and again on Dec 24, and again on Dec 25, and again with Me 25 and again on Dec 25 and again with Me 25 an	eember edical unable ecember firmed lfilled April 4,	F 0573			
F 0740 SS=D				F 0740			

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	ATEMENT OF DEFICIENCIES AND AN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER				PLE CONSTRUCTION:	(X3) DATE SURV COMPLETED:	EY
		395545			BLDG:00_ WING: 04/26/2023		
ACCELA I SPRINGFI	VIDER OR SUPPLIER: REHAB AND CARE CENT ELD SE NUMBER: 580502	TER AT	STREET ADDRESS. 850 PAPERM GLENSIDE, I	ILL ROAD	MP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0740	Continued from page 5			F 0740			
SS=D	483.40 Behavioral Health S §483.40 Behavioral health s Each resident must receive a necessary behavioral health maintain the highest practic psychosocial well-being, in comprehensive assessment a health encompasses a reside mental well-being, which in prevention and treatment of disorders. This REQUIREMENT is no	services. and the facility must proceare and services to attate able physical, mental, and accordance with the and plan of care. Behavent's whole emotional and acludes, but is not limite mental and substance united.	in or nd ioral d d to, the		Resident R9 is currently foll psych services and no furthe recommendations have been this time. Pharmacy recommendations reviewed by MD for gradual reductions regarding psycho medications and any recomm follow up with behavioral he services will be completed in manner by DON/designee Re- education regarding the policy on providing behavio health services in a timely m residents prescribed psychot medications reviewed will b provided to licensed nursing DON/designee An audit of 10 residents with dose recommendations will audited for recommended fo with behavioral health service timely manner by the DON/wkly for four weeks and mothereafter The findings of the audit will brought to Quality Improver Committee monthly for three an quarterly thereafter	a made at a will be I dose I	Completion Date: 05/11/2023 Status: APPROVED Date: 05/12/2023

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395545		B. WING: _		04/26/2023		
NAME OF PROVIDER OR SUPPLIER: ACCELA REHAB AND CARE CENTER AT SPRINGFIELD STATE LICENSE NUMBER: 580502			STREET ADDRESS, 850 PAPERM GLENSIDE, P	ILL ROAD	IIP CODE:			
(X4) ID PREFIX TAG	ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEF IX MUST BE PRECEEDED BY FULL REGULATORY OR			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0740	Continued from page 6			F 0740				
SS=D								
	Based on review of clin	nical records and sta	ff					
	interview, it was determ		-					
	provide behavioral hea		•					
	for one of three residen		otropic					
	medications reviewed ((Resident R9).						
	Findings Include:							
	Review of Resident R9's Quarterly Minimum Data Set (federally mandated resident assessment and care screening) dated February 11, 2023, revealed the resident had diagnoses of depression (mood disorder that causes persistent feeling of sadness) and bipolar disease (mental disorder that causes extreme mood swings that include emotional highs and lows).							
	Review of Resident R9 September 28, 2020, re exhibited sexually inap taking roommates belo Resident R9's care plan 2020, revealed the resid	evealed the resident opropriate behaviors ngings. Further revia a revised September	ew of 28,					

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	R: A. BLDG: <u>00</u>		00_	(X3) DATE SURVEY COMPLETED:	
395545				B. WING: _		04/26/2023	
ACCELA I SPRINGFI	VIDER OR SUPPLIER: REHAB AND CARE CENT ELD E NUMBER: 580502	TER AT	850 PAPERM GLENSIDE, I	ILL ROAD	IIP CODE:		
(X4) ID PREFIX	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH		(X5) COMPLETE
TAG	IDENTI	FYING INFORMATION)			CROSS-REFERENCED TO THE A	APPROPRIATE	DATE
F 0740	Continued from page 7			F 0740			
SS=D	related to robbery with expected death of fami	1					
	Continued review of Resident R9's care plan rev September 28, 2020, revealed the resident was o psychotropic medication (describes any drug tha affects behavior, mood, thoughts, or perception) management of bipolar and major depression. Intervention dated October 26, 2020, included psych consult as ordered.						
	Review of Resident RS revealed a physician or psych consult and treat diagnosis of depression R9's physician order su was prescribed medica depression, Tramadol a Trazodone for insomni	2021 for Resident resident					
	Review of Resident R9 Review Physician Rep Employee E4, dated No	ort by consultant pha	armacist,				

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	ATEMENT OF DEFICIENCIES AND AN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395545		B. WING:		04/26/2023	
NAME OF PROVIDER OR SUPPLIER: ACCELA REHAB AND CARE CENTER AT SPRINGFIELD STATE LICENSE NUMBER: 580502			STREET ADDRESS, 850 PAPERM GLENSIDE, F	ILL ROAD	IIP CODE:		
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	DROVIDED'S DI AN OE CODDE	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE IDENTII	ED BY FULL REGULATORY OF		PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	COMPLETE DATE
F 0740	Continued from page 8			F 0740			
SS=D							
	recommendations to ev	·	-				
	and Trazodone medica	tions for serotonin e	ffects.				
	The report was signed						
	Employee E5, and indi		was				
	obtained that the physic	•					
	recommendations and		ent was				
	"to be followed by psy	ch."					
	Review of Resident R9	o's Consultant Pharm	acist				
	Review Physician Repo	ort by consultant pha	armacist,				
	Employee E4, dated De	ecember 6, 2022, rev	vealed				
	recommendations to ev	aluate if a gradual d	lose				
	reduction could be con	sidered for Trazodor	ne. The				
	report was signed by R	-					
	E5, and indicated a ver						
	the physician disagreed						
	note to "continue to fol	llow up with psych."					
	Review of Resident R9	o's psych consults pro	ovided				
	by the facility revealed	the resident was no	t seen for				
	follow-up until April 1	3, 2023.					
	Interview on April 26,	2023, at 5:30 p.m. w	vith				

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			00	(X3) DATE SURVEY COMPLETED:	
		395545		B. WING: _		04/26/2023	
NAME OF PROVIDER OR SUPPLIER: ACCELA REHAB AND CARE CENTER AT SPRINGFIELD STATE LICENSE NUMBER: 580502			STREET ADDRESS, 850 PAPERMI GLENSIDE, P	ILL ROAD			
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (EACH	(X5)
PREFIX TAG		D BY FULL REGULATORY OF FYING INFORMATION)	R LSC	PREFIX TAG	CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	COMPLETE DATE	
F 0740	Continued from page 9			F 0740			
SS=D	Nursing Home Admini Director of Nursing, En						
	further psych evaluatio						
	rattier psychievariatio	ns were avanable at	tills tillic.				
	28 Pa. Code 201.21 Us	es					
	28 Pa. Code 201.18 (e)	(6) Management					
F 0758				F 0758			
SS=D							

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					(X3) DATE SURVEY COMPLETED:	
	395545				04/26/2023	
VIDER OR SUPPLIER: REHAB AND CARE CENT ELD E NUMBER: 580502	TER AT	850 PAPERM	ILL ROAD	MP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFI			ID PREFIX TAG	CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETE DATE
Continued from page 10			F 0758			
Meds/PRN Use §483.45(e) Psychotropic Dr §483.45(c)(3) A psychotrop brain activities associated w behavior. These drugs inclu drugs in the following categ (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Hypnotic Based on a comprehensive a facility must ensure that §483.45(e)(1) Residents wh drugs are not given these dr necessary to treat a specific documented in the clinical r §483.45(e)(2) Residents wh receive gradual dose reducti interventions, unless clinica to discontinue these drugs; §483.45(e)(3) Residents do pursuant to a PRN order unl	ugs. ic drug is any drug that ith mental processes and, de, but are not limited tories: assessment of a resident on have not used psychotogs unless the medication condition as diagnosed ecord; o use psychotropic drug ons, and behavioral lly contraindicated, in an out receive psychotropic ess that medication is	affects d o, the ropic on is and s n effort		from the facility. Review of recommendations by behavioral specialists will reviewed for residents in the to ensure that a residents right free from unnecessary psych medications by DON/Design Re- education on facility pol regarding a residents right to from unnecessary psychotrop medications will be provided licensed nursing staff by DON/designee. An audit of 10 residents on psychotropic medications wi completed to ensure that asso of medications and dosage at followed to ensure that resid right to be free from unneces psychotropic medications by DON/Designee wkly for fou and monthly thereafter The findings of the audit will brought to Quality Improvements	s made I be e facility nt to be otropic nee icy, be free pic I to all II be essment re ents essary r weeks I be nent	Completion Date: 05/23/2023 Status: APPROVED Date: 05/12/2023
-	•					
	VIDER OR SUPPLIER: REHAB AND CARE CENT ELD E NUMBER: 580502 SUMMARY STATEMENT MUST BE PRECEEDE IDENTE Continued from page 10 483.45(c)(3)(e)(1)-(5) Free Meds/PRN Use §483.45(c)(3) A psychotropic Dr §483.45(c)(3) A psychotropic prain activities associated with behavior. These drugs includrugs in the following categi (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive a facility must ensure that §483.45(e)(1) Residents with drugs are not given these drugs are not given these drucessary to treat a specific documented in the clinical r §483.45(e)(2) Residents with receive gradual dose reduction interventions, unless clinicated discontinue these drugs; §483.45(e)(3) Residents do pursuant to a PRN order unlescessary to treat a diagnose.	VIDER OR SUPPLIER: REHAB AND CARE CENTER AT ELD ENUMBER: 580502 SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION) Continued from page 10 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotrop Meds/PRN Use §483.45(c)(3) A psychotropic drug is any drug that brain activities associated with mental processes and behavior. These drugs include, but are not limited to drugs in the following categories: (i) Anti-apsychotic; (ii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident facility must ensure that §483.45(e)(1) Residents who have not used psychot drugs are not given these drugs unless the medication necessary to treat a specific condition as diagnosed documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drug receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in at to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic pursuant to a PRN order unless that medication is	IDENTIFICATION NUMBER: 395545 WIDER OR SUPPLIER: REHAB AND CARE CENTER AT ELD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 10 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use \$483.45(e) Psychotropic Drugs. \$483.45(e)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that \$483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; \$483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; \$483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is	A BLDG: 395545 STREET ADDRESS, CITY, STATE, Z 850 PAPERMILL ROAD GLENSIDE, PA 19038 E NUMBER: 580502 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 10 F 0758 483.45(c)(3)(c)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use \$483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that \$483.45(c)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; \$483.45(c)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; \$483.45(c)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is	A BLDG:	RECTION (POC) DESTIFICATION NUMBER: A BLDG 00 B WING: COMPLETED

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
	395545			A. BLDG:00 B. WING:		04/26/2023	
ACCELA I SPRINGFI	VIDER OR SUPPLIER: REHAB AND CARE CENT ELD E NUMBER: 580502	EER AT	STREET ADDRESS, 850 PAPERMI GLENSIDE, P	ILL ROAD	MP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0758	Continued from page 11			F 0758			
SS=D	§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:		the eves ed tionale ation are e				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395545				04/26/2023	
NAME OF PROVIDER OR SUPPLIER: ACCELA REHAB AND CARE CENTER AT SPRINGFIELD STATE LICENSE NUMBER: 580502			STREET ADDRESS, 850 PAPERMI GLENSIDE, P	ILL ROAD	IIP CODE:	,	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0758	Continued from page 12			F 0758			
SS=D	Based on review of factorecords, and staff intersthe facility failed to ensunnecessary psychotrosthree residents reviewed medications (Resident Findings Include: Review of undated factorecomplete Medications and Gradustevealed residents who medications shall receive and behavioral interventhese drugs. The staff as whether continued use the resident. Review of Resident R2 Minimum Data Set (few assessment and care sec 2023, revealed the resident intervention of the second s	view, it was determinated a resident was a resident was a spic medications for a deformation of a medication in all Drug Dose Reductions in efforts to determine and practitioner will of a medication is but its Significant Change derally mandated respectives and practice of a medication in the control of a medication in the control of a medication in the control of a medication is but its significant Change derally mandated respectively.	g ction" uctions iscontinue determine enefiting ge sident uary 23, o the				

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			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/26/2023	
3'	95545		B. WING: _		04/26/2023	
NAME OF PROVIDER OR SUPPLIER: ACCELA REHAB AND CARE CENTER SPRINGFIELD STATE LICENSE NUMBER: 580502	RAT	STREET ADDRESS, 850 PAPERMI GLENSIDE, P.	LL ROAD	IP CODE:		
(X4) ID SUMMARY STATEMENT OF I PREFIX MUST BE PRECEEDED B	O ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI FIX MUST BE PRECEEDED BY FULL REGULATORY OF			PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0758 Continued from page 13 SS=D intact. Further review of the resident had a diagnosis of disorder that causes persists. Further review of Resident revealed the resident was facility on March 27, 2022. Review of Resident R2's of 2023, revealed the resident medication (describes any behavior, mood, thoughts, management of depression. Review of Resident R2's properties of the resident was facility on March 27, 2023. Review of Resident R2's properties of the resident was facility on March 27, 2023. Review of Resident R2's properties of the resident was facility on March 27, 2023. Review of Resident R2's properties of the resident was facility on March 27, 2023. Continued review of depression of the resident was facility on March 27, 2023. Review of Resident R2's properties of the resident was facility on March 27, 2023. Review of Resident R2's properties of the resident was facility on March 27, 2023. Review of Resident R2's properties of the resident was facility on March 27, 2023. Review of Resident R2's properties of the resident was facility on March 27, 2023.	of depression (moostent feeling of sach at R2's clinical recordischarged from the second seco	the od dness). ord he April 5, ropic r ed apployee ty post ental ion.	F 0758			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395545				04/26/2023	
NAME OF PROVIDER OR SUPPLIER: ACCELA REHAB AND CARE CENTER AT SPRINGFIELD STATE LICENSE NUMBER: 580502			STREET ADDRESS, 850 PAPERMI GLENSIDE, P	ILL ROAD	IIP CODE:	,	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0758 SS=D	chart which revealed the hospital on a low dose (treats conditions that of Risperidone which independent R2 was noted behaviors. Recommendations by RE6, included to discont milligrams (mg) daily 2023. Review of Resident R2 resident's Risperidone recommended by the N26, 2023. Review of Resident R2 record revealed the reserved Risperidone a 2023, through March 1	anti-psychotic medicause or involve psychetic depression with no changes in Nurse Practitioner, Finue Risperidone 0.3 in 14 days, on January climical record reviews not discontinued furse Practitioner on the system of the syst	cation chosis) of ssion. mood or Employee 25 ry 26, vealed the d as January	F 0758			

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
395545				<u></u>	04/26/2023		
ACCELA I SPRINGFI	VIDER OR SUPPLIER: REHAB AND CARE CENT ELD SE NUMBER: 580502	EER AT	STREET ADDRESS, 850 PAPERM GLENSIDE, F	ILL ROAD			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0758	Continued from page 15			F 0758			
SS=D	28 Pa Code 201.14(a) 1 28 Pa Code 201.18(b)(28 Pa code 211.12 (d)	1) Management					
F 0835 SS=A	483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:		ain or	F 0835	As per CMS and discussion DOH, no POC is required. The facility will provide con and timely documentation for completed clinical records as requested by the Department Health	nplete or s	Completion Date: 05/23/2023 Status: APPROVED Date: 05/16/2023

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PLAN OF CORRECTION (POC) (A1) PROVIDER SUPPLIER C IDENTIFICATION NUMBER: 395545			A. BLDG: _	00	COMPLETED: 04/26/2023	5 Y
NAME OF PROVIDER OR SUPPLIER: ACCELA REHAB AND CARE CENTER AT SPRINGFIELD STATE LICENSE NUMBER: 580502		STREET ADDRESS, 850 PAPERM GLENSIDE, F	ILL ROAD	IP CODE:		
(X4) ID SUMMARY STATEME PREFIX MUST BE PRECEE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIE MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	(X5) COMPLETE DATE	
Based on review of continued from page 16 SS=A Based on review of continued interview, it was determined to three clinical recommedication reviews (Findings include: On April 26, 2023, and requested via email to Administrator, Employereviews for the last the for Resident R8 and Monthly pharmacy reduction and was on November 2022, Dece 2023. The facility did reviews for Resident March 2023. The facility did reviews for Resident March 2023. The facility available for Subsequently, the face	rmined that the facilital timely documentation described for month Resident R8 and R9). 2:14 p.m. State survey the Nursing Home by the Nursing Home by the E1, monthly phase are months and psychology. Eviews were not providly provided for the member 2022, and Janual not provide monthly R8 and R9 for Februal lity still did not have review.	eyor armacy h notes ded until conths of uary pharmacy ary or psych	F 0835			

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	I) PROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED:	
		395545		B. WING: _		04/26/2023		
NAME OF PROVIDER OR SUPPLIER: ACCELA REHAB AND CARE CENTER AT SPRINGFIELD STATE LICENSE NUMBER: 580502			STREET ADDRESS, CITY, STATE, ZIP CODE: 850 PAPERMILL ROAD GLENSIDE, PA 19038					
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	(X5) COMPLETE DATE		
F 0835	Continued from page 17			F 0835				
SS=A	3-hours after request for 2023, at 5:30 p.m.		pril 26,					
	28 Pa Code: 211.5(f) C							
	28 Pa Code: 211.12(d)							
F 0840				F 0840				
SS=D								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
				00	04/26/2023		
NAME OF PROVIDER OR SUPPLIER: ACCELA REHAB AND CARE CENTER AT SPRINGFIELD STATE LICENSE NUMBER: 580502			STREET ADDRESS, 850 PAPERM GLENSIDE, F	ILL ROAD	IP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFIC PREFIX MUST BE PRECEEDED BY FULL REGULATORY OR L TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0840 SS=D	Continued from page 18 483.70(g)(1)(2) Use of Outside re §483.70(g)(1) If the facility professional person to furnis provided by the facility, the furnished to residents by a p facility under an arrangement of the Act or an agreement of the Act or agreements per by outside resources must sp facility assumes responsibility (i) Obtaining services that m principles that apply to professuch a facility; and (ii) The timeliness of the ser	does not employ a qual- sh a specific service to be facility must have that seerson or agency outside at described in section 1 described in paragraph (as as described in section retaining to services furn pecify in writing that the dity for- neet professional standar essionals providing services.	service the 861(w) g)(2) of 1861(w) ished	F 0840	Resident R2 has been dischard Residents that are preparing discharge will have documer evidence that the facility communicates to residents rescheduled appointments and for the resident upon dischard DON/Designee RE-education on the facility to provide provision of profeservices furnished by outside providers will be conducted licensed nursing staff by DON/Designee An audit of the last 2 weeks discharges will be completed ensure that documented evidence that documented evidence appointments and tests upon discharge are documented are provided to the resident by DON/designee An audit of the weekly dischard will be completed to ensure that documented evidence of the	for inted segarding tests age by sessional se with all of the dence of s to d sarges	Completion Date: 05/23/2023 Status: APPROVED Date: 05/12/2023
					facility's communications to residents regarding schedule appointments and tests upon	d	

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PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395545			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/26/2023		
NAME OF PROVIDER OR SUPPLIER: ACCELA REHAB AND CARE CENTER AT SPRINGFIELD STATE LICENSE NUMBER: 580502		STREET ADDRESS, 850 PAPERM GLENSIDE, P	ILL ROAD	IP CODE:			
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	(X5) COMPLETE DATE	
F 0840 SS=D	Continued from page 19			F 0840	discharge are documented ar provided to the resident by DON/designee weekly for for weeks and quarterly thereaft. The findings of the audit will brought to Quality Improven Committee monthly for three an quarterly thereafter	our er. I be nent	

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
395545			B. WING:		04/26/2023		
NAME OF PROVIDER OR SUPPLIER: ACCELA REHAB AND CARE CENTER AT SPRINGFIELD STATE LICENSE NUMBER: 580502			850 PAPERM GLENSIDE, I	ILL ROAD	IP CODE:		
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEF PREFIX MUST BE PRECEEDED BY FULL REGULATORY OR			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0840 SS=D	Based on review of clininterviews, it was deter to provide provision of furnished by outside presidents reviewed (Refindings Include: Review of Resident R2 Set (federally mandated care screening) dated Just the resident was admitted November 10, 2022, at Further review of the Mada diagnosis of chologallbladder). Review of Resident R2 dated December 30, 20 was sent to the hospital complaints of abdomine Review of Resident R2 R2 Review of Resident R2 Review of Resident R2 R2 Review of Resident R2 Review of Resident R2	Professional services roviders for one of testident R2). Professional services roviders for one of testident R2). Professional services roviders for one of testident R2). Professional services rovident R2. Professional services resident R2. Professional services rovident R2.	ity failed es en um Data nt and vealed ntact. sident ion of	F 0840			

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OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
395545			1		04/26/2023	
NAME OF PROVIDER OR SUPPLIER: ACCELA REHAB AND CARE CENTER AT SPRINGFIELD STATE LICENSE NUMBER: 580502		850 PAPERM	ILL ROAD	IIP CODE:		
SUMMARY STATEMENT MUST BE PRECEEDE		ID PREFIX TAG	CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETE DATE	
scan in the hospital shoinfection. Surgery was Resident R2 not a cand a tube in the resident's (known as a cholecysto Review of a report of c 13, 2023, revealed Residentage consult after cholecystostomy tube. physician included to c gastroenterology and for completed. Review of Resident R2 revealed no documente scheduled an appointm subsequent follow-up for Review of Resident R2 dated March 27, 2023,	consulted but deemed a possible gall be consulted but deemed a gallbladder to drain ostomy tube). consultation dated Fedident R2 had a post placement of the Recommendations of the consult with upper collow-up after consult with upper collow-up after consult with gastroenter for the cholecystosto. It is discharge paperwise to do commendation of the cholecystosto. It is discharge paperwise discharge discharge paperwise discharge discharge discharge discharge disc	oladder ed d placed the fluid ebruary From the alt ord ity ology or omy tube. ork	F 0840			
	a any bonounou					
	PREVIEW OF RESIDENT Cholecystostomy tube. physician included to c gastroenterology and focompleted. Review of Resident R2 revealed no documente scheduled an appointm subsequent follow-up for Review of Resident R2 revealed no documente scheduled an appointm subsequent follow-up for Review of Resident R2 revealed Resident R2 revealed no documente scheduled an appointm subsequent follow-up for Review of Resident R2 revealed Resident R2 revealed no documente scheduled an appointm subsequent follow-up for Review of Resident R2 revealed R2 revealed R4 review of Resident R2 revealed R5 review of R6 resident R2 revealed R5 revealed R5 review of R6 resident R2 revealed R5 review of R6 resident R2 review of R6 revie	PRECTION (POC) IDENTIFICATION NUMBER 395545 VIDER OR SUPPLIER: REHAB AND CARE CENTER AT ELD ENUMBER: 580502 SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION) Continued from page 21 paperwork dated January 10, 2023, revealed scan in the hospital showed a possible gall infection. Surgery was consulted but deem. Resident R2 not a candidate for surgery and a tube in the resident's gallbladder to drain (known as a cholecystostomy tube). Review of a report of consultation dated Fe 13, 2023, revealed Resident R2 had a post discharge consult after placement of the cholecystostomy tube. Recommendations in physician included to consult with upper gastroenterology and follow-up after consuction completed. Review of Resident R2's entire clinical recompleted. Review of Resident R2's entire clinical recompleted. Review of Resident R2's entire clinical recompleted. Review of Resident R2's entire clinical recompleted.	VIDER OR SUPPLIER: REHAB AND CARE CENTER AT ELD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 21 paperwork dated January 10, 2023, revealed a CT scan in the hospital showed a possible gallbladder infection. Surgery was consulted but deemed Resident R2 not a candidate for surgery and placed a tube in the resident's gallbladder to drain the fluid (known as a cholecystostomy tube). Review of a report of consultation dated February 13, 2023, revealed Resident R2 had a post discharge consult after placement of the cholecystostomy tube. Recommendations from the physician included to consult with upper gastroenterology and follow-up after consult completed. Review of Resident R2's entire clinical record revealed no documented evidence the facility scheduled an appointment with gastroenterology or subsequent follow-up for the cholecystostomy tube. Review of Resident R2's discharge paperwork dated March 27, 2023, revealed no documented	IDENTIFICATION NUMBER: 395545 STREET ADDRESS, CITY, STATE, REHAB AND CARE CENTER AT ELD ENUMBER: 580502 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 21 F 0840 Continued from page 21 F 0840 F 0840 Review of a report of consultation dated February 13, 2023, revealed Resident R2 had a post discharge consult after placement of the cholecystostomy tube. Recommendations from the physician included to consult with upper gastroenterology and follow-up after consult completed. Review of Resident R2's entire clinical record revealed no documented evidence the facility scheduled an appointment with gastroenterology or subsequent follow-up for the cholecystostomy tube. Review of Resident R2's discharge paperwork dated March 27, 2023, revealed no documented	DENTIFICATION NUMBER: 395545 STREET ADDRESS, CITY, STATE, ZIP CODE: 850 PAPERMILL ROAD GLENSIDE, PA 19038 ENUMBER: 580502 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIDST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 21 paperwork dated January 10, 2023, revealed a CT scan in the hospital showed a possible gallbladder infection. Surgery was consulted but deemed Resident R2 not a candidate for surgery and placed a tube in the resident's gallbladder to drain the fluid (known as a cholecystostomy tube). Review of a report of consultation dated February 13, 2023, revealed Resident R2 had a post discharge consult after placement of the cholecystostomy tube. Recommendations from the physician included to consult with upper gastroenterology and follow-up after consult completed. Review of Resident R2's entire clinical record revealed no documented evidence the facility scheduled an appointment with gastroenterology or subsequent follow-up for the cholecystostomy tube. Review of Resident R2's discharge paperwork dated March 27, 2023, revealed no documented	A BLDG: 00 B WING: S9545 A BLDG: 00 B WING: S9545 A BLDC: 00 B WING: S9545 A BLD: 00

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395545		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/26/2023	
NAME OF PROVIDER OR SUPPLIER: ACCELA REHAB AND CARE CENTER AT SPRINGFIELD			STREET ADDRESS, 850 PAPERM GLENSIDE, P	ILL ROAD	IIP CODE:		
	E NUMBER: 580502						
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0840	Continued from page 22			F 0840			
SS=D	appointments and tests discharge. Interview on April 26, Director of Nursing, Endocumented evidence vappointments for Residence vappointments and tests discharge.	vith ned no					
	28 Pa. Code: 201.21(a)	Use of Outside Res	sources				
	28 Pa. Code: 201.21(b)) Use of Outside Res	sources				
	28 Pa. Code: 201.21 (c) Use of Outside Resources						
	28 Pa Code:201.18(b)(1) Management						

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Certified End Page

ACCELA REHAB AND CARE CENTER AT SPRINGFIELD

STATE LICENSE NUMBER: 580502 SURVEY EXIT DATE: 04/26/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY